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H. Sale of facility. In the event of the sale of a NF, the prospective base operating cost rates for the new owner's first fiscal period shall be the seller's prospective base operating cost rates before the sale.

I. Public notice. To comply with the requirements of § 1902(a)(28)(c) of the Social Security Act, DMAS shall make available to the public the data and methodology used in establishing Medicaid payment rates for nursing facilities. Copies may be obtained by request under the existing procedures of the Virginia Freedom of Information Act.

12VAC30-90-42 through 12VAC30-90-43. Repealed.

12VAC30-90-44 to 12VAC30-90-49. Reserved

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Article 3

Allowable Cost Identification

12VAC30-90-50. Allowable costs.

A. Costs which are included in rate determination procedures and final settlement shall be only those allowable, reasonable costs which are acceptable under the Medicare principles of reimbursement, except as specifically modified in the Plan and as may be subject to individual or ceiling cost limitations and which are classified in accordance with the DMAS uniform chart of accounts (see 12VAC30-90-270).

B. Certification. The cost of meeting all certification standards for NF requirements as required by the appropriate state agencies, by state laws, or by federal legislation or regulations.

C. Operating costs.

1. Direct patient care operating costs shall be defined in 12VAC30-90-270.

2. Allowable direct patient care operating costs shall exclude (i) personal physician fees, and (ii) pharmacy services and prescribed legend and non-legend drugs provided by nursing facilities which operate licensed in-house pharmacies. These services shall be billed directly to DMAS through separate provider agreements and DMAS shall pay directly in accordance with 12VAC30-80-10 et seq.

3. Indirect patient care operating costs include all other operating costs, not identified as direct patient care operating costs and NATCEPs costs in 12VAC30-90-270, which

are allowable under the Medicare principles of reimbursement, except as specifically modified herein and as may be subject to individual cost or ceiling limitations.

D. Allowances/goodwill. Bad debts, goodwill, charity, courtesy, and all other contractual allowances shall not be recognized as an allowable cost.

12VAC30-90-51. Purchases/related organizations.

A. Costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control shall be included in the allowable cost of the provider at the cost to the related organization, provided that such costs do not exceed the price of comparable services, facilities or supplies. Purchases of existing NFs by related parties shall be governed by the provisions of 12VAC30-90-34 B 2.

Allowable cost applicable to management services furnished to the provider by organizations related to the provider by common ownership or control shall be lesser of the cost to the related organization or the per patient day ceiling limitation established for management services cost. (See 12VAC30-90-290.)

B. "Related to the provider" shall mean that the provider is related by reasons of common ownership or control by the organization furnishing the services, facilities, or supplies.

C. Common ownership exists when an individual or individuals or entity or entities possess significant ownership or equity in the parties to the transaction. Control exists where an individual or individuals or entity or entities have the power, directly or indirectly, significantly to influence or direct the actions or policies of the parties to the transaction.

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Significant ownership or control shall be deemed to exist where an individual is a "person with an ownership or control interest" within the meaning of 42 CFR 455.101. If the parties to the transaction are members of an immediate family, as defined below, the transaction shall be presumed to be between related parties if the ownership or control by immediate family members, when aggregated together, meets the definitions of "common ownership" or "control," as set forth above. Immediate family shall be defined to include, but not be limited to, the following: (i) husband and wife, (ii) natural parent, child and sibling, (iii) adopted child and adoptive parent, (iv) step-parent, step-child, step-sister, and step-brother, (v) father-in-law, mother-in-law, sister-in-law, brother-in-law, son-in-law and daughter-in-law, and (vi) grandparent and grandchild.

D. Exception to the related organization principle.

1. Effective with cost reports having fiscal years beginning on or after July 1, 1986, an exception to the related organization principle shall be allowed. Under this exception, charges by a related organization to a provider for goods or services shall be allowable cost to the provider if all four of the conditions set out below are met.

2. The exception applies if the provider demonstrates by convincing evidence to the satisfaction of DMAS that the following criteria have been met:

   a. The supplying organization is a bona fide separate organization. This means that the supplier is a separate sole proprietorship, partnership, joint venture, association or corporation and not merely an operating division of the provider organization.

   b. A substantial part of the supplying organization's business activity of the type carried on with the provider is transacted with other organizations not related to

the provider and the supplier by common ownership or control and there is an open, competitive market for the type of goods or services furnished by the organization. In determining whether the activities are of similar type, it is important to also consider the scope of the activity.

For example, a full service management contract would not be considered the same type of business activity as a minor data processing contract. The requirement that there be an open, competitive market is merely intended to assure that the item supplied has a readily discernible price that is established through arms-length bargaining by well informed buyers and sellers.

c. The goods or services shall be those which commonly are obtained by institutions such as the provider from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by such institutions. This requirement means that institutions such as the provider typically obtain the good or services from outside sources rather than producing the item internally.

d. The charge to the provider is in line with the charge for such services, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for such goods or services. The phrase "open market" takes the same meaning as "open, competitive market" in subdivision b above.

3. Where all of the conditions of this exception are met, the charges by the supplier to the provider for such goods or services shall be allowable as costs.

4. This exception does not apply to the purchase, lease or construction of assets such as property, buildings, fixed equipment or major movable equipment. The terms "goods and services" may not be interpreted or construed to mean capital costs associated with such purchases, leases, or construction.

12VAC30-90-52. Administrator/owner compensation.

A. Administrators' compensation, whether administrators are owners or nonowners, shall be based on a schedule adopted by DMAS and varied according to facility bed size. The compensation schedule shall be adjusted annually to reflect cost-of-living increases and shall be published and distributed to providers annually. The administrator's compensation schedule covers only the position of administrator and assistants and does not include the compensation of owners employed in capacities other than the nursing facility administrator (see 12VAC30-90-290, Cost reimbursement limitations).

B. Administrator compensation shall mean remuneration paid regardless of the form in which it is paid. This includes, but shall not be limited to, salaries, professional fees, insurance premiums (if the benefits accrue to the employee/owner or his beneficiary), director fees, personal use of automobiles, consultant fees, management fees, travel allowances, relocation expenses in excess of IRS guidelines, meal allowances, bonuses, pension plan costs, and deferred compensation plans. Management fees, consulting fees, and other services performed by owners shall be included in the total compensation if they are performing administrative duties regardless of how such services may be classified by the provider.

C. Compensation for all administrators (owner and nonowner) shall be based upon a 40-hour week to determine reasonableness of compensation.

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D. Owner/administrator employment documentation.

1. Owners who perform services for a nursing facility as an administrator and also perform additional duties must maintain adequate documentation to show that the additional duties were performed beyond the normal 40-hour week as an administrator. The additional duties must be necessary for the operation of the nursing facility and related to patient care.

2. Services provided by owners, whether in employee capacity, through management contracts, or through home office relationships shall be compared to the cost and services provided in arms-length transactions.

3. Compensation for such services shall be adjusted where such compensation exceeds that paid in such arms-length transactions or where there is a duplication of duties normally rendered by an administrator. No reimbursement shall be allowed for compensation where owner services cannot be documented and audited.

12VAC30-90-53 through 12VAC30-90-54. Repealed.

12VAC30-90-55. Provider payments.

A. Limitations.

1. Payments to providers, shall not exceed charges for covered services except for (i) public providers furnishing services free of charge or at a nominal charge (ii)

nonpublic provider whose charges are 60% or less of the allowable reimbursement represented by the charges and that demonstrates its charges are less than allowable reimbursement because its customary practice is to charge patients based on their ability to pay. Nominal charge shall be defined as total charges that are 60% or less of the allowable reimbursement of services represented by these charges. Providers qualifying in this section shall receive allowable reimbursement as determined in this Plan.

2. Allowable reimbursement in excess of charges may be carried forward for payment in the two succeeding cost reporting periods. A new provider may carry forward un-reimbursed allowable reimbursement in the five succeeding cost reporting periods.

3. Providers may be reimbursed the carry forward to a succeeding cost reporting period (i) if total charges for the services provided in that subsequent period exceed the total allowable reimbursement in that period (ii) to the extent that the accumulation of the carry forward and the allowable reimbursement in that subsequent period do not exceed the providers' direct and indirect care operating ceilings plus allowable plant cost

B. Payment for service shall be based upon the rate in effect when the service was rendered.

C. For cost reports filed on or after August 1, 1992, an interim settlement shall be made by DMAS within 180 days after receipt and review of the cost report. The 180-day time frame shall similarly apply to cost reports filed but not interim settled as of August 1, 1992. The word "review," for purposes of interim settlement, shall include verification that all financial and other data specifically requested by DMAS is submitted with the cost report. Review shall also mean examination of the cost report and other required submission for obvious errors, inconsistency, inclusion of past disallowed costs,

unresolved prior year cost adjustments and a complete signed cost report that conforms to the current DMAS requirements herein.

However, an interim settlement shall not be made when one of the following conditions exists:

1. Cost report filed by a terminated provider;

2. Insolvency of the provider at the time the cost report is submitted;

3. Lack of a valid provider agreement and de-certification;

4. Moneys owed to DMAS;

5. Errors or inconsistencies in the cost report; or

6. Incomplete/non-acceptable cost report.

12VAC30-90-56. Legal fees/accounting.

A. Costs claimed for legal/accounting fees shall be limited to reasonable and customary fees for specific services rendered. Such costs must be related to patient care as defined by Medicare principles of reimbursement and subject to applicable regulations herein. Documentation for legal costs must be available at the time of audit.

B. Retainer fees shall be considered an allowable cost up to the limits established in 12VAC30-90-290.

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C. As mandated by the Omnibus Budget Reconciliation Act of 1990, effective November 5, 1990, reimbursement of legal expenses for frivolous litigation shall be denied if the action is initiated on or after November 5, 1990. Frivolous litigation is any action initiated by the nursing facility that is dismissed on the basis that no reasonable legal ground existed for the institution of such action.

12VAC30-90-57. Documentation.

Adequate documentation supporting cost claims must be provided at the time of interim settlement, cost settlement, audit, and final settlement.

12VAC30-90-58. Fraud and abuse.

Previously disallowed costs which are under appeal and affect more than one cost reporting period shall be disclosed in subsequent cost reports if the provider wishes to reserve appeal rights for such subsequent cost reports. The reimbursement effect of such appealed costs shall be computed by the provider and submitted to DMAS with the cost report. Where such disclosure is not made to DMAS, the inclusion of previously disallowed costs may be referred to the Medicaid Fraud Control Unit of the Office of the Attorney General.

12VAC30-90-59. [Reserved]

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Article 4

New Nursing Facilities

12VAC30-90-60. Interim rate.

A. Effective July 1, 2000, for all new or expanded NFs the 90% occupancy requirement for indirect and plant costs shall be waived for establishing the first cost reporting period interim rate. This first cost reporting period shall not exceed 12 months from the date of the NF's certification.

B. Upon a showing of good cause, and approval of the DMAS, an existing NF that expands its bed capacity by 50% or more shall have the option of retaining its prospective rate, or being treated as a new NF.

C. The 90% occupancy requirement for indirect and plant costs shall be applied to the first and subsequent cost reporting periods' actual indirect and plant costs for establishing such NF's second and future cost reporting periods' prospective reimbursement rates. The 90% occupancy requirement shall be considered as having been satisfied if the new NF achieved a 90% occupancy at any point in time during the first cost reporting period.

D. A new NF's interim rate for the first cost reporting period shall be determined based upon the lower of its anticipated allowable cost determined from a detailed budget (or pro forma cost report) prepared by the provider and accepted by the DMAS, or the appropriate operating ceilings or charges.

E. Effective July 1, 2000, on the first day of its second cost reporting period, a new nursing facility's interim plant rate shall be converted to a per diem amount by dividing it by the

number of patient days computed as 90% of the daily licensed bed complement during the first cost reporting period.

F. During its first semiannual period of operation, a newly constructed or newly enrolled NF shall have an assigned SII based upon its peer group's average SII for direct patient care. An expanded NF receiving new NF treatment shall receive the SII calculated for its last semiannual period prior to obtaining new NF status.

12VAC30-90-65. Final rate.

The DMAS shall reimburse the lower of the appropriate operating ceilings, charges or actual allowable cost for a new NF's first cost reporting period of operation, subject to the procedures outlined above in 12VAC30-90-60 A, C, E, and F.

Upon determination of the actual allowable operating cost for direct patient care and indirect patient care the per diem amounts shall be used to determine if the provider is below the peer group ceiling used to set its interim rate. If indirect costs are below the ceiling, an efficiency incentive shall be paid at settlement of the first year cost report.

This incentive will allow a NF to be paid up to 25% of the difference between its actual allowable indirect operating cost and the peer group ceiling used to set the interim rate. (Refer to 12VAC30-90-41 F.)

12 VAC 30-90-66 through 12 VAC 30-90-69. Reserved.

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Article 5

Cost Reports

12VAC30-90-70. Cost report submission.

A. Cost reports are due not later than 150 days after the provider's fiscal year end. If a complete cost report is not received within 150 days after the end of the provider's fiscal year, it is considered delinquent. The cost report shall be deemed complete for the purpose of cost settlement when DMAS has received all of the following (note that if the audited financial statements required by subdivisions 3 a and 6 b of this subsection are received not later than 120 days after the provider's fiscal year end and all other items listed are received not later than 90 days after the provider's fiscal year end, the cost report shall be considered to have been filed at 90 days):

1. Completed cost reporting form(s) provided by DMAS, with signed certification(s);

2. The provider's trial balance showing adjusting journal entries;

3. a. The provider's audited financial statements including, but not limited to, a balance sheet, a statement of income and expenses, a statement of retained earnings (or fund balance), a statement of cash flows, the auditor's report in which he expresses his opinion or, if circumstances require, disclaims an opinion based on generally accepted auditing standards, footnotes to the financial statements, and the management report. Multi-facility providers shall be governed by subdivision 6 of this subsection;

b. Schedule of restricted cash funds that identify the purpose of each fund and the amount;

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4. Schedules which reconcile financial statements and trial balance to expenses claimed in the cost report;

5. Depreciation schedule;

6. Nursing facilities which are part of a chain organization must also file:

   a. Home office cost report;

   b. Audited consolidated financial statements of the chain organization including the auditor's report in which he expresses his opinion or, if circumstances require, disclaims an opinion based on generally accepted auditing standards, the management report and footnotes to the financial statements;

   c. The nursing facility's financial statements including, but not limited to, a balance sheet, a statement of income and expenses, a statement of retained earnings (or fund balance), and a statement of cash flows;

   d. Schedule of restricted cash funds that identify the purpose of each fund and the amount;

   e. Schedule of investments by type (stock, bond, etc.), amount, and current market value; and

7. Such other analytical information or supporting documentation that may be required by DMAS.

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B. When cost reports are delinquent, the provider's interim rate shall be reduced to zero. For example, for a September 30 fiscal year end, payments will be reduced starting with the payment on and after March 1.

C. After the overdue cost report is received, desk reviewed, and a new prospective rate established, the amounts withheld shall be computed and paid. If the provider fails to submit a complete cost report within 180 days after the fiscal year end, a penalty in the amount of 10% of the balance withheld shall be forfeited to DMAS.

12VAC30-90-75. Reporting form; accounting method; cost report extensions; fiscal year changes.

A. All cost reports shall be submitted on uniform reporting forms provided by the DMAS, or by Medicare if applicable. Such cost reports, subsequent to the initial cost report period, shall cover a 12-month period. Any exceptions must be approved by the DMAS.

B. The accrual method of accounting and cost reporting is mandated for all providers.

C. Extension for submission of a cost report may be granted if the provider can document extraordinary circumstances beyond its control. Extraordinary circumstances do not include:

1. Absence or changes of chief finance officer, controller or bookkeeper;

2. Financial statements not completed;

3. Office or building renovations;

4. Home office cost report not completed;

5. Change of stock ownership;

6. Change of intermediary;

7. Conversion to computer; or

8. Use of reimbursement specialist.

D. All fiscal year end changes must be approved 90 days prior to the beginning of a new fiscal year.

Article 6

Prospective Rates

12VAC30-90-80. Time frames.

A. For cost reports filed on or after August 1, 1992, a prospective rate shall be determined by DMAS within 90 days of the receipt of a complete cost report. (See 12VAC30-90-70 A.) The 180-day time frame shall similarly apply to cost reports filed but for which a prospective rate has not been set as of August 1, 1992. Rate adjustments shall be made retroactive to the first day of the provider's new cost reporting year. Where a field audit is necessary to set a prospective rate, the DMAS shall have an additional 90 days to determine any appropriate adjustments to the prospective rate as a result of such field audit. This time period shall be extended if delays are attributed to the provider.

B. Subsequent to establishing the prospective rate DMAS shall conclude the desk audit of a providers' cost report and determine if further field audit activity is necessary. The DMAS will seek repayment or make retroactive settlements when audit adjustments are made to costs claimed for reimbursement.

Article 7

Retrospective Rates

12VAC30-90-90. Retrospective rates.

The retrospective method of reimbursement shall be used for mental health/mental retardation facilities.

12VAC30-90-100. Reserved

Article 8

Record Retention

12VAC30-90-110. Record retention.

A. Time frames. All of the NF's accounting and related records, including the general ledger, books of original entry, and statistical data must be maintained for a minimum of five years, or until all affected cost reports are final settled.

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Certain information must be maintained for the duration of the provider's participation in the DMAS and until such time as all cost reports are settled. Examples of such information are set forth in subsection B of this section.

B. Types of records to be maintained. Information which must be maintained for the duration of the provider's participation in the DMAS includes, but is not limited to:

1. Real and tangible property records, including leases and the underlying cost of ownership;

2. Itemized depreciation schedules; and

3. Mortgage documents, loan agreements, and amortization schedules;

4. Copies of all cost reports filed with the DMAS together with supporting financial statements.

C. Record availability. The records must be available for audits by DMAS staff. Where such records are not available, costs shall be disallowed.

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Article 9

Audits

12VAC30-90-120. Audit overview; scope of audit.

A. Desk audits shall be performed to verify the completeness and accuracy of the cost report, and reasonableness of costs claimed for reimbursement. Field audits, as determined necessary by the DMAS, shall be performed on the records of each participating provider to determine that costs included for reimbursement were accurately determined and reasonable, and do not exceed the ceilings or other reimbursement limitations established by the DMAS.

B. The scope of the audit includes, but shall not be limited to: trial balance verification, analysis of fixed assets, indebtedness, selected revenues, leases and the underlying cost of ownership, rentals and other contractual obligations, and costs to related organizations. The audit scope may also include various other analyses and studies relating to issues and questions unique to the NF and identified by the DMAS. Census and related statistics, patient trust funds, and billing procedures are also subject to audit.

12VAC30-90-121. Field audit requirements.

Field audits shall be required as follows:

1. For the first cost report on all new NF's.

2. For the first cost report in which costs for bed additions or other expansions are included.

3. When a NF is sold, purchased, or leased.

4. As determined by DMAS desk audit.

12VAC30-90-122. Provider notification.

The provider shall be notified in writing of all adjustments to be made to a cost report resulting from desk or field audit with stated reasons and references to the appropriate principles of reimbursement or other appropriate regulatory cites.

12VAC30-90-123. Field audit exit conference.

A. The provider shall be offered an exit conference to be executed within 15 days following completion of the on-site audit activities, unless other time frames are mutually agreed to by the DMAS and provider. Where two or more providers are part of a chain organization or under common ownership, DMAS shall have up to 90 days after completion of all related on-site audit activities to offer an exit conference for all such NFs. The exit conference shall be conducted at the site of the audit or at a location mutually agreeable to the DMAS and the provider.

B. The purpose of the exit conference shall be to enable the DMAS auditor to discuss such matters as the auditor deems necessary, to review the proposed field audit adjustments, and to present supportive references. The provider will be given an opportunity during

the exit conference to present additional documentation and agreement or disagreement with the audit adjustments.

C. All remaining adjustments, including those for which additional documentation is insufficient or not accepted by the DMAS, shall be applied to the applicable cost report or reports regardless of the provider's approval or disapproval.

D. The provider shall sign an exit conference form that acknowledges the review of proposed adjustments.

E. After the exit conference the DMAS shall perform a review of all remaining field audit adjustments. Within a reasonable time and after all documents have been submitted by the provider, the DMAS shall transmit in writing to the provider a final field audit adjustment report (FAAR), which will include all remaining adjustments not resolved during the exit conference. The provider shall have 15 days from the date of the letter which transmits the FAAR, to submit any additional documentation which may affect adjustments in the FAAR.

12VAC30-90-124. Audit delay.

In the event the provider delays or refuses to permit an audit to occur or to continue or otherwise interferes with the audit process, payments to the provider shall be reduced as stated in 12VAC30-90-70 B.

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12VAC30-90-125. Field audit time frames.

A. If a field audit is necessary after receipt of a complete cost report, such audit shall be initiated within three years following the date of the last notification of program reimbursement and the on site activities, including exit conferences, shall be concluded within 180 days from the date the field audit begins. Where audits are performed on cost reports for multiple years or providers, the time frames shall be reasonably extended for the benefit of the DMAS and subject to the provisions of 12VAC30-90-123.

B. Documented delays on the part of the provider will automatically extend the above time frames to the extent of the time delayed.

C. Extensions of the time frames shall be granted to the department for good cause shown.

D. Disputes relating to the timeliness established in 12VAC30-90-123 and 12VAC30-90-124, or to the grant of extensions to the DMAS, shall be resolved by application to the Director of the DMAS or his designee.

12VAC30-90-126 to 12VAC30-90-129. Reserved

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Subpart III

Appeals

12VAC30-90-130.

A. NF's have the right to appeal the DMAS's interpretation and application of state and federal Medicaid and applicable Medicare principles of reimbursement in accordance with the Administrative Process Act, § 9-6.14:1 et seq. and § 32.1-325.1 of the Code of Virginia.

B. Nonappealable issues are identified below:

1. The use of state and federal Medicaid and applicable Medicare principles of reimbursement.

2. The organization of participating NF's into peer groups according to location as a proxy for cost variation across facilities with similar operating characteristics. The use of individual ceilings as a proxy for determining efficient operation within each peer group.

3. Calculation of the initial peer group ceilings using the most recent cost settled data available to DMAS that reflects NF operating costs inflated to September 30, 1990.

4. The use of the moving average of the Skilled Nursing Facility market basket of routine service costs, as developed by Data Resources, Incorporated, adjusted for Virginia, as the prospective escalator.

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5. The establishment of separate ceilings for direct operating costs and indirect operating costs.

6. The use of Service Intensity Indexes to identify the resource needs of given NFs patient mix relative to the needs present in other NFs.

7. The development of Service Intensity Indexes based on:

   a. Determination of resource indexes for each patient class that measures relative resource cost.

   b. Determination of each NF's average relative resource cost index across all patients.

   c. Standardizing the average relative resource cost indexes of each NF across all NF's.

8. The use of the DMAS Long Term Care Information System (LTCIS), assessment form (currently DMAS-95), Virginia Center on Aging Study, the State of Maryland Time and Motion Study of the Provision of Nursing Service in Long Term Care Facilities, and the KPMG Peat Marwick Survey of Virginia long-term care NF's nursing wages to determine the patient class system and resource indexes for each patient class.

9. The establishment of payment rates based on service intensity indexes.

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12VAC30-90-131. An appeal shall not be heard until the following conditions are met:

1. Where appeals result from desk or field audit adjustments, the provider shall have received a notification of program reimbursement (NPR) in writing from the DMAS. .

2. Any and all moneys due to DMAS shall be paid in full, unless a repayment plan has been agreed to by DMAS. .

3. All first level appeal requests shall be filed in writing with the DMAS within 90 business days following the date of a DMAS notice of program reimbursement that adjustments have been made to a specific cost report. .

12VAC30-90-132. Administrative appeals.

A. There shall be two levels of administrative appeal.

B. Informal appeals shall be decided by the Director of the Appeals Division after an informal fact finding conference is held. The decision of the Director of the Appeals Division shall be sent in writing to the provider within 90 business days following conclusion of the informal fact finding conference.

C. If the provider disagrees with such initial decision the provider may, at its discretion, file a notice of appeal to the Director of the DMAS. Such notice shall be in writing and filed within 30 business days of the date of the initial decision.

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D. Within 30 business days of the date of such notice of appeal, the director shall appoint a hearing officer to conduct the proceedings, to review the issues and the evidence presented, and to make a written recommendation.

E. The director shall notify the provider of his final decision within the time frames set for disposition of appeals in this subpart and the Administrative Process Act, § 9-6.14:1 et seq. of the Code of Virginia.

F. The director's final written decision shall conclude the provider's administrative appeal.

G. Formal hearing procedures, as developed by DMAS, shall control the conduct of the formal administrative proceedings.

12VAC30-90-133. Appeal time frames noted throughout this section may be extended for the following reasons:

1. The provider submits a written request prior to the due date requesting an extension for good cause and the DMAS approves the extension.

2. Delays on the part of the NF documented by the DMAS shall automatically extend DMAS's time frame to the extent of the time delayed.

3. Extensions of time frames shall be granted to the DMAS for good cause shown.

4. When appeals for multiple years are submitted by a NF or a chain organization or common owners are coordinating appeals for more than one NF, the time frames shall be reasonably extended for the benefit of the DMAS.

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5. Disputes relating to the time lines established in 12VAC30-90-132 B or to the grant of extensions to the DMAS shall be resolved by application to the Director of the DMAS or his designee.

12VAC30-90-134. Dispute resolution for state-operated NFs.

A. Definitions.

"DMAS" means the Department of Medical Assistance Services.

"Division director" means the director of a division of DMAS.

"State-operated provider" means a provider of Medicaid services which is enrolled in the Medicaid program and operated by the Commonwealth of Virginia.

B. Right to request reconsideration.

1. A state-operated provider shall have the right to request a reconsideration for any issue which would be otherwise administratively appealable under the State Plan by a non-state operated provider. This shall be the sole procedure available to state-operated providers. .

2. The appropriate DMAS division must receive the reconsideration request within 30 business days after the date of a DMAS Notice of Amount of Program Reimbursement, notice of proposed action, findings letter, or other DMAS notice giving rise to a dispute. .

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C. Informal review. The state-operated provider shall submit to the appropriate DMAS division written information specifying the nature of the dispute and the relief sought. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought; the amount of the adjustment sought; and the reasons for seeking the adjustment. The division director or his designee shall review this information, requesting additional information as necessary. If either party so requests, they may meet to discuss a resolution. Any designee shall then recommend to the division director whether relief is appropriate in accordance with applicable law and regulations.

D. Division director action. The division director shall consider any recommendation of his designee and shall render a decision.

E. DMAS director review. A state-operated provider may, within 30 business days after the date of the informal review decision of the division director, request that the DMAS Director or his designee review the decision of the division director. The DMAS Director shall have the authority to take whatever measures he deems appropriate to resolve the dispute.

F. Secretarial review. If the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider, within 30 business days after the date of the decision of the DMAS Director, the provider may request the DMAS director to refer the matter to the Secretary of Health and Human Resources and any other cabinet secretary as appropriate. Any determination by such secretary or secretaries shall be final.